



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BELEN HALL
5420 WEST LOOP SOUTH # 3600
BELLAIRE, TX 77401

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-2894-01

MFDR Date Received

May 14, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "BILL REVIEW DEPARTMENT (Rick Ball) states DRG 454 per APC rate is \$15,264.00. Wrong APC rate is \$38,544.32. REV 278 should have paid \$39,061.43 and markup \$2,000."

Amount in Dispute: \$33,249.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual claim 99J0000542350 is in the Texas Star Network."

Response Submitted by: Texas Mutual Insurance Company, 6210 E HWY 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 02, 2011	Inpatient Hospital Services	\$33,249.78	\$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. Texas Insurance Code Chapter 1305 set outs the procedures for Workers' Compensation Health Care Networks.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 25, 2011, November 21, 2011, January 30, 2012 and March 09, 2012,

- CAC-219 – Based on Extent of Injury.
- 246 – The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place.

- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891 – No additional payment after reconsideration.
- CAC-W1 – Workers Compensation State Fee Schedule adjustment.
- CAC-131 – Claim specific negotiated discount.
- CAC-97 – The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- 420 – Supplemental payment.
- 468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology.
- 729 – This bill was reviewed accordance with your First Health Contract.
- 897 – Separate reimbursement for implantables made in accordance with DWC Rule Chapter 134: Subchapter (E) Health Facility Fees.

Issues

1. Is the Requestor eligible for Medical Fee Dispute Resolution pursuant to 28 Texas Administrative Code §133.305 and §133.307?

Findings

1. The insurance carrier denied disputed service with reason code “219 – Based on extent of injury” and “246 – The treatment/service has been determined to be unrelated to the extent of injury.” Review of the medical bill finds that the principal diagnosis code is 724.2 – Spinal Stenosis of lumbar region, 401.9 – Unspecified essential hypertension, 305.1 – Nondependent tobacco use disorder and 349 – Other & Unspecified disorder the nervous system.” A contested case hearing was held December 30, 2010 and April 26, 2011 to address the extent of injury issues regarding the injured worker’s compensable injury. As a result, a contested case hearing decision and order was reached and signed by all parties stating that the compensable injury of August 18, 2008 extends to include L3-L4, L4-L5 disc herniations with L5 radiculopathy. All issues of extent of injury related to the services in dispute have been resolved. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. This dispute was filed at the Texas Department of Insurance, Division of Workers’ Compensation (Division), Medical Fee Dispute Resolution section on May 14, 2012 for resolution pursuant to 28 Texas Administrative Code §133.307.

28 Texas Administrative Code §133.305 (a)(4) defines a Medical Fee Dispute as “A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee’s compensable injury.” Non-network health care is defined in Section (a)(6) of the same rule as “Health care not delivered, or arranged by a certified workers’ compensation health care network as defined in Insurance Code Chapter 1305 and related rules...” 28 Texas Administrative Code §133.307 (a)(1) similarly states that “This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care...” Therefore, pursuant to 28 Texas Administrative Code §133.307, the Divisions Medical Fee Dispute Resolution section may not address fee disputes involving health care delivered, or arranged by a certified network as defined by Insurance Code Chapter 1305, but may resolve disputes involving certain authorized out-of-network health care.

Out-of-network health care is defined in Insurance Code Chapter 1305, section 1305.006 titled Insurance Carrier Liability for Out-of-Network Health Care. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. Therefore, the dispute may not be resolved pursuant to 28 Texas Administrative Code §133.307, and Medical Fee Dispute Resolution is not the appropriate venue for resolution of the dispute filed by the requestor.

Conclusion

For the reasons stated above, the Division concludes that Medical Fee Dispute is not the appropriate venue for resolution of the issued raised by the requestor. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ 6/28/12 Date
--------------------	---	--------------------------

_____ Signature	_____ Medical Fee Dispute Resolution Manager	_____ 6/28/12 Date
--------------------	---	--------------------------

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.